

Louisiana State Board of Nursing

17373 Perkins Road
Baton Rouge, LA 70810
Telephone: (225) 755-7500 Fax: (225) 755-7583
<http://www.lsbn.state.la.us>

MEDICATION REPORT

To the practitioner of the Recovering Nurse Program participant:

Please take a few moments to complete the form below. After completing the form please mail it to the office within five (5) days of prescribing the medication. The completed form must be mailed by the practitioner only. If you have any questions, please call (225) 755-7546.

Name of Individual: _____
(Please Print)

Date of Medical Examination: _____
(Date)

Diagnoses: _____

By signature below, I verify that the information below is correct. I have been informed that this individual is a participant in the Recovering Nurse Program and that he/she submits to random drug screens. The use of narcotics or controlled substances should be avoided when alternative treatments are available.

PRESCRIPTION INFORMATION

DATE OF PRESCRIPTION OR REFILL	NAME OF MEDICATION	QUANTITY & DOSAGE NUMBER OF REFILLS	REASON FOR MEDICATION	CONTROLLED, MOOD ALTERING, OR ADDICTIVE	
				YES	NO

Individual's Signature

Prescriber Signature

License # or SSN

Prescriber's Name (Please Print)

Date

Prescriber's Address

Area Code/Phone Number